Exchanges Plan Management Function: Accreditation & Quality
DRAFT: June 15, 2012
As adopted by the Exchanges (B) Subgroup Accreditation & Quality Team on June 15, 2012

Underlining and overstrikes show changes from the 6/15 draft distributed prior to Team adoption.

Any comments on this draft should be sent only by email to Jane Sung at jsung@naic.org by COB on **Thursday, June 21, 2012**.

Formatted: Font: Bold

Outline:

1. Introduction
2. Summary of Federal Requirements
3. Accreditation Requirements
    a. Requirement to Oversee Assessment and Ratings of Health Care Quality and Outcomes
    b. Quality Reporting Requirements of QHP Issuers
    c. Sharing of Accreditation Information on QHP Issuers with Exchanges
    d. Requirement to Establish Time Frames for Accreditation
    e. How Well Does Accreditation Line Up with Policy Forms?
    f. Dental Plans
    g. Co-ops
4. Quality Elements in the Exchanges
    a. QHP Quality Improvement Strategies
    b. Requirement to Oversee Implementation of Enrollee Satisfaction Surveys
    c. Requirement to Support a Website That Provides Standardized Comparative Information on Quality Ratings
    d. Quality Best Practices and Related Issues
5. Distinctions Based on Exchange status

1. Introduction:

The Patient Protection and Affordable Care Act (ACA) provides for the establishment of American Health Benefit Exchanges (Exchanges). An Exchange must offer only Qualified Health Plans (QHPs) certified by the Exchange to qualified individuals and qualified employers. To participate in an Exchange, QHPs are required to meet accreditation standards and must implement a quality improvement strategy. The ACA addresses the obligations of the Secretary of Health and Human Services (HHS), the Exchange, the State, the issuer, and the QHP itself.

As part of a national quality strategy, Exchanges will have a significant role in: ensuring that QHPs become accredited and implement quality improvement strategies; providing plan ratings based on quality and cost; and providing patient satisfaction data. The purposes of these requirements are to improve the quality of health care, ensure that QHPs are focused on

promoting quality improvement, and improve transparency so that consumers can compare plans based on quality as well as price.

This paper is intended to provide a resource to help states understand the obligations of the Exchange with regard to accreditation and quality. The paper also addresses situations where states have options, including situations where options may exist but federal guidance on specifics is not yet available.

2. Summary of Federal Requirements

The ACA quality and accreditation requirements are excerpted at the end of this paper for easy reference. Federal law obligates the Exchange to be responsible for certain quality and accreditation elements. With regard to quality and accreditation, the Exchange must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, among many other Exchange dues and responsibilities that are beyond the scope of this paper. The Exchange website must provide standardized comparative information on each QHP, including quality ratings and results of enrollee surveys.

QHP issuers must be accredited by an accrediting entity that meets HHS standards and reflects a variety of quality parameters such as clinical quality, access, satisfaction, among others. A QHP issuer must receive such accreditation within a time period established by an Exchange, if not already accredited. A QHP issuer must adopt a quality improvement strategy that incorporates increased reimbursement or other incentives for improved health outcomes, prevention of hospital readmissions, improved patient safety, reduced medical errors, wellness, and reduced healthcare disparities. An accredited QHP issuer is required to authorize its accrediting entity to share information with HHS and the Exchange. An accredited QHP issuer must maintain its accreditation for as long as it offers QHPs on the Exchange.

3. Accreditation Requirements

a. Requirement to Oversee Assessment of Health Care Quality and Outcomes

An Exchange must oversee assessment of health care quality and health outcomes. This requirement is at least in part fulfilled by assuring that QHPs are accredited.

Accreditation is an obligation of the QHP issuer.[1] If the QHP issuer does not become accredited within the specific time frame or the QHP issuer does not remain accredited, the QHP will not be certified. An issuer that is not accredited by a recognized accrediting entity on the basis of

[1] The Affordable Care Act of 2010 (ACA) (Public Law 111-148, as amended by Public Law 111-152), Section 1311(c)(1)(D)(i).

local performance of its QHP will not be certified to sell coverage through the Exchanges. Exchanges are obligated to oversee this assessment of health care quality and outcomes.[2]

The ACA does not name a specific accrediting entity but requires that the accreditation must be awarded by an organization that is formally recognized by HHS. There are currently two nationally recognized organizations, the National Committee for Quality Assurance (NCQA) and URAC, that have evolved over the last 20 years for the express purpose of accrediting health plans.[3] The Accreditation Association for Ambulatory Health Care (AAAHC) that has focused primarily on accrediting ambulatory care facilities, but also has over thirty years of experience with accrediting health plans and is recognized by CMS as a deemed accrediting organization for Medicare Advantage Plans.[4] As of the drafting date of this paper, other accrediting entities have not been recognized by HHS or made themselves known to state insurance regulators.

In a proposed rule[5], HHS announced a two-step process for recognizing accrediting entities. In phase one, HHS proposes to recognize NCQA and URAC on an interim basis, subject to certain conditions.[6] In phase two, HHS intends to establish an application procedure, standards for recognition, a criteria-based review of applications, public participation, and public notice of the recognition for entities seeking to become a recognized accrediting entity.[7] If an accrediting entity is not included in the final regulation on recognition of accrediting entities, it is anticipated that they would need to go through the federal recognition process described in the phase two process.

States may wish to consider whether there is a role for state recognition of accrediting organizations. Although the ACA and federal regulations require accreditation to be made by an HHS recognized entity, it is unclear whether there could also be a role for state recognition. Allowing federal and state certification under uniform federal standards may be a desirable way to balance the goals of ensuring that all accrediting entities meet the same standards, while also allowing state flexibility to certify accrediting entities that may be state specific or otherwise better suited to state rather than national recognition. This could potentially serve the goal of giving issuers more choices in accrediting entities and preserve the role of states in selecting accrediting entities.

[2] Establishment of Exchanges and Qualified Health Plans, Final Rule, 77. Fed. Reg. (March 27, 2012), 45 CFR §155.200(d). The Final Rule states "The Exchange must…oversee implementation of…"assessment and ratings of health care quality and outcomes in accordance with sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Affordable Care Act".

[3] For more information about the history and activity of each of these organizations, please see their websites: www.ncqa.org and www.urac.org.

[4] For more information about the history and activity of the AAAHC, please see its website: www.aaahc.org.

[5] Recognition of Entities for the Accreditation of Qualified Health Plans, Proposed Rule, 77 Fed. Reg. 33133 (June 5, 2012).

[6] The conditions are specified in §156.275(c)(2)-(4) of the Proposed Rule on Recognition of Entities. The Proposed Rule noted that NCQA meets and URAC is planning to meet, these conditions.

[7] This future rulemaking will be 45 CFR §156.275(c)(1)(ii).

The ACA does not preclude the possibility of recognition of organizations other than NCQA and URAC, including AAAHC, state-recognized entities or state-specific organizations to fulfill the accreditation purposes. It appears possible that a state could have a unique state-specific accreditation body that could seek HHS or state recognition.

In order to earn accreditation from an HHS recognized accrediting entity, a QHP issuer is evaluated in a review that includes quality improvement activities, credentialing of providers, network adequacy standards, utilization management practices, providing information to consumers, enrollee satisfaction surveys, and assessment and ratings of health care quality and outcomes. Accrediting entities typically evaluate health plans in an initial application process, an ongoing oversight process, and a recertification process.

In overseeing this process, State-operated Exchanges could consider adopting a similar approach as HHS in allowing a choice of qualified accreditation entities, including those designated now and in the future by CMS. Such an approach would allow QHP issuers flexibility to choose an accreditation entity that best meets their needs and could reduce costs for issuers since there would be competition between accreditors. Alternatively, states may want to choose one accreditation program, as a number of states do for their Medicaid programs. This could allow for consistency in evaluation, quality measure collection and approach to scoring plans. It should be noted however, that states are able to require uniform measure sets, even if multiple accrediting bodies are operating in a state.

A key question to be addressed is how well current accreditation processes fulfill ACA requirements. Both NCQA and URAC have provided crosswalk materials outlining where their specific accreditation standards correlate to ACA requirements. Similar crosswalk information is also available from AAAHC. States may wish to consider an arrangement where accreditation by one or more of the national organizations will be presumed to show compliance with additional QHP requirements beyond the baseline requirement that all QHPs be accredited. However, States should not cede regulatory authority so they can take action if they determine that additional oversight is required.

Although the ACA requires an Exchange to address certain quality-related issues (including evaluating quality improvement strategies, overseeing implementation of enrollee satisfaction, assessments, comparative ratings and outcomes), there may be an opportunity to realize considerable administrative savings, as well as valuable consumer protection, by deferring to the organizations that already address these dimensions as part of their accreditation programs, and have decades of experience as well. ~~Currently, fifteen states provide that nationally recognized accrediting entities may apply for recognition as a "deemed accreditor" for health plans consistent with the approach in those laws.~~ Accreditors report that currently as many as 41 states have some level of accreditor recognition. State certification of accrediting entities, if utilized, should be limited however to the state in which it is granted.

Exchanges should also align and prepare to be able to receive and evaluate the data that would be necessary to fulfill accrediting and quality obligations. Accreditation is a tool for regulators

and purchasers that does not serve as a replacement for regulatory oversight, but is a complement to state review. It offers as an objective evaluation of critical quality activities (e.g. quality improvement, credentialing or provider directories) not currently included in a state's plan audit processes. For areas where accreditation overlaps with existing state requirements (e.g. utilization management/review) the review can help Exchanges and their state regulatory partners in the assessment of initial and ongoing qualification.

States that decide to use the results of accreditation to satisfy some state requirements may wish to be careful to ensure that QHP certification processes do not duplicate the activities of accrediting entities or establish differing regulatory requirements, which could add to administrative costs. States should consider the extent to which data submitted on the accreditation survey may be used to fulfill other quality reporting standards.

b. Quality Reporting Requirements of QHP Issuers

While quality reporting requirements for QHP issuers and Exchanges will be the subject of future federal rulemaking, HHS has indicated support for an approach which allows for harmonization of measures across programs. In guidance on federally facilitates Exchanges, HHS stated that they intend "…to solicit stakeholder input on the most effective ways to align the quality reporting and display requirements for QHPs in 2016 and beyond with related quality measurement initiatives across HHS (for example, the National Quality Strategy, section 2717 of the Affordable Care Act, and quality reporting requirements under Medicare and Medicaid."

In the interim, the ACA and the final Exchange rule require that QHP issuers must "be accredited on the basis of local performance by an accrediting entity recognized by HHS in the following nine categories:

(i) Clinical quality measures, such as the Healthcare Effectiveness Data and Information Set [HEDIS];
(ii) Patient experience ratings on a standardized CAHPS survey;
(iii) Consumer access;
(iv) Utilization management;
(v) Quality assurance;
(vi) Provider credentialing;
(vii) Complaints and appeals;
(viii) Network adequacy and access; and
(ix) Patient information programs

Accreditation programs must include clinical quality measures. In recent proposed rules, CMS put forward the following criteria that clinical measures must meet to satisfy the accreditation clinical quality measure requirement.

- Span a breadth of conditions and domains, including, but not limited to, preventive care, mental health and substance abuse disorders, chronic care, and acute care;

- Include measures that are applicable to adults and separate measures that are applicable to children;
- Align with the priorities of the National Strategy for Quality Improvement in Health Care
- Only include measures that are either developed or adopted by a voluntary consensus standards setting body (such as those described in the National Technology and Transfer Advancement of Act of 1995 (NTTAA) and Office of Management and Budget (OMB) Circular A-119 (1998)) or, where appropriate endorsed measures are unavailable, are in common use for health plan quality measurement and meet health plan industry standards; and,
- Be evidence based.

While the clinical quality measures for NCQA and URAC have similarities and differences, both have undergone initial review by CCIIO and, thus far, appear to meet HHS requirements. Prior to issuing this proposed rule and identifying NCQA and URAC for potential recognition, CCIO has worked to become fully aware of the current standards and clinical quality measures employed by both NCQA and URAC. A final review and approval of both URAC's and NCQA's programs including measures, will be performed by HHS prior to announcing formal recognition in a final rule to be published in the Federal Register.

This chart summarizes the measure set domains for the two accrediting entities, NCQA and URAC, that were named in the proposed rule:

URAC Measures	NCQA (HEDIS®[8]) Measures
• Patient centeredness • Coordination of care • Care efficiency • Effectiveness of care • Patient safety • Health plan management and administration • Systemness or health information technology integration • Health care disparities	Measures scored in accreditation: • Prevention and screening • Respiratory conditions • Cardiovascular conditions • Diabetes • Muculoskeletal conditions • Behavioral health

Detailed clinical quality measure sets for both URAC and NCQA are available at their respective websites: www.ncqa.org and www.urac.org. In addition, information about the AAAHC quality measure sets can be obtained by contacting AAAHC at info@aaahc.org.

[8] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

It should also be noted that, while NCQA has developed and maintained the HEDIS measure set, URAC's program can also accept HEDIS measures for issuers already using that system of reporting. NCQA also has a system for collecting and auditing non-HEDIS quality measure data and can work to collect non-HEDIS or CAHPs quality data.

Under the ACA, states may require quality measures in addition to those required by the accrediting entities. URAC's program allows for states to supplement its requirements in this manner. States may also be interesting in asking plans to address certain state-specific data that is not included in reports from accreditors. For example, states with a significant mining industry may ask health plans in that state to report data and improve the quality of health care services related to illnesses and injuries associated with mining activities. However, states should consider balancing the imposition of any new quality measures with increased compliance costs.

c. Sharing of Accreditation Information on QHP Issuers with Exchanges

45 CFR §156.275(a)(2) requires QHP issuers to "authorize the accrediting entity that accredits the QHP issuer to release to the Exchange and HHS a copy of its most recent accreditation survey, **together with any survey related information that HHS may require**[bolding added], such as corrective action plans and summaries of findings." NCQA does provide states with quality measure results. On the other hand, URAC routinely provides states with a copy of the accreditation report, and gives them an opportunity to receive additional information. The accrediting entities recognize that the ACA requires an increased level of information sharing than has occurred in the past, and goes beyond what the accrediting entities currently make publicly available.

In their proposed rule, HHS proposes that, when authorized by an accredited QHP issuer, the accreditation entities provide certain data elements to the Exchange during the annual certification period or as changes occur to the data throughout the coverage year. These data elements include: name, address, Health Insurance Oversight System (HIOS) issuer identifier, unique accreditation identifier(s) of the QHP issuer and its accredited product(s) and type(s) which have been released. In addition, for each accredited product type: the HIOS product identifier; accreditation status, survey, type or level; accreditation score; expiration date of accreditation; and clinical quality measures and CAHPS measure survey results.[9]

The accrediting entities have expressed interest in working with the federal government, the NAIC and state Exchanges to provide necessary plan accreditation information with the QHP issuer's authorization. In doing so, it is anticipated that the accrediting entities will put in place any necessary data agreements before sharing the information.[10] The proposed rule also

[9] This is included in the Proposed Rule on Recognition of Entities as §156.275(c)(5).

[10] The type of data agreement may vary depending on the use of the information. For example, if a state Exchange intends to publicly report information from an accreditation review, a different data agreement may be needed than if a state were intending to use the information solely for QHP certification purposes.

provides that Exchanges will be permitted to enter into these types of data sharing agreements if they choose to require additional information, and asks for additional comment on whether accrediting entities should be required to provide this additional information upon request from an Exchange.[11]

At a minimum, state regulators should receive sufficient information to ensure ACA compliance. Even if an Exchange is able to use the results of accreditation to satisfy some of the oversight requirements, the Exchange should arrange to have access to the data sets that are collected for accreditation purposes. If Exchanges review any other data that may be proprietary, or require HIPAA privacy and security protections, the Exchange should observe the HIPAA minimally necessary standard, and ensure the protection of confidential or proprietary data.

States should also consider which is the appropriate agency to receive such information, as it may not always be the state insurance department. State insurance regulators are likely already familiar with the SERFF (System for Electronic Rate and Form Filings) system for form and rate filings. The NAIC is currently in ongoing discussions with NCQA and URAC regarding SERFF's role as a data conduit in order to present data in a way that is helpful for state review. The NAIC's Market Conduct Annual Statement (MCAS) may also be a potential data sharing platform in the future if very large data sets are involved. However, because MCAS is not currently used for health insurance, the development and refinement of a health application for MCAS could be a lengthy endeavor. Both SERFF and MCAS are tools well known to state insurance regulators, but for states where the Exchange is not overseen by the DOI or in states where there is a federally facilitated Exchange, these platforms may not be the obvious first choice of the Exchange. HHS has a growing familiarity with SERFF, although state Medicaid and public health agencies are unlikely to be familiar with SERFF. States may wish to consider the use of these platforms as a means to harmonize with overlapping DOI and Exchange activities.

d. Requirement to Establish Time Frames for Accreditation

For QHP issuers that are not already accredited, Exchanges are required to establish a uniform period following certification of a QHP within which the issuer must become accredited.[12] In determining a time frame to achieve accreditation, state insurance regulators should be aware of the reasons that some health plans are not currently accredited. Accreditation has traditionally been driven by public and private purchasers requiring accreditation of plans in order for the plans to participate in the market, for the plans to receive preferential contracts and to provide or supplement oversight. Prior to the ACA, some plans decided not to pursue accreditation due to cost. State or regional provider-sponsored plans are less likely to have the preferential contract opportunities or market incentives to dedicate resources to earning formal accreditation. These plans may be aware of the accreditation evaluation standards and measures, and strive to comport themselves following those standards, although it is not

[11] This is included in the Proposed Rule on Recognition of Entities.
[12] 45 CFR § 155.1045.

possible to determine whether the non-accredited plans are, in fact, meeting industry standards and measures and monitoring quality.

States may wish to analyze the status of their non-accredited issuers to determine if sufficient criteria exist (based on the plan's documented efforts to operate like an accredited plan) to provide some kind of monetary or technical assistance for those plans to get them to formal accreditation. This may be an especially important consideration for the new co-ops, which have no previous experience operating as a health plan, let alone an accredited health plan.[13] It is reasonable that states may be concerned about providing assistance to such smaller and newer plans. However, more established insurers who are already accredited and issuers currently undergoing the accreditation process may have objections to the competitive disadvantage posed by assistance to newer and smaller issuers. In addition, state Exchanges should carefully consider, if such an issuer does not have the resources to complete initial accreditation, whether they would have difficulty funding the ongoing costs of maintaining the operational infrastructure to meet the accreditation standards and cost of renewal accreditation fees. In addition, Exchanges may want to weigh this expense against other more pressing needs, given scarce resources.

The accrediting entities are also aware of the challenges facing new plans, such as the co-ops, and plans that aren't currently accredited but are interested in pursuing accreditation. New issuers will not have a history of complex case management files that can be reviewed or a history of claims that can be used to report clinical quality measures. ~~Both NCQA and URAC~~ All three known accrediting entities (NCQA, URAC and AAAHC) have provisional or interim accreditation programs to accommodate these types of situations.[14]

In guidance on federally facilitated Exchanges, HHS announced that non-accredited QHP issuers will be required to schedule an accreditation in their first year of certification and be accredited by completion of the second year of certification. The guidance also indicates the federally facilitated Exchange will accept NCQA or URAC accreditation of a commercial or Medicaid QHP in the same state in which the issuer is seeking to offer Exchange coverage until the fourth year of certification. This approach is designed to accommodate the needs of new entrants and Medicaid QHPs seeking certification as a QHP.

[13] 45 CFR §156.515(c)(2) states "Loan recipients must offer a CO-OP qualified health plan … in every individual market Exchange ... If offering at least one plan in the small group market, loan recipients must offer a CO-OP qualified health plan in each SHOP ..."

[14] URAC grants provisional accreditation if the plan meets standards for policies and procedures, but does not have sufficient operational or consumer enrollment to receive full accreditation. NCQA has created an Interim and First Accreditation programs for new or currently unaccredited issuers and will first review policies and procedures, then review plan files and performance once the plan builds a history of enrollment. AAAHC's Early Options Survey (EOS) program is for plans in operation for 6 months or less, and plans are granted accreditation but must then undergo an additional interim survey during the accreditation term.

In establishing a time line or grace period, states should be aware that the accrediting entities have indicated that the typical accreditation process for a previously unaccredited issuer takes an average of 18 months to prepare and an additional 3 months for the accreditor review process. For issuers not already accredited, the January 1, 2014 timeframe is achievable since URAC and NCQA both offer provisional or interim accreditation that could be granted in that time frame.

~~One interpretation of the ACA is that currently non-accredited issuers should achieve accreditation by January 1, 2014. Since the accrediting entities have indicated that the typical accreditation process takes an average of 18 months to prepare and 3 months for accreditor review, issuers currently not accredited should be working now to get accredited in time to begin offering QHPs on the Exchanges. For issuers not already accredited, the January 1, 2014 date is achievable for NCQA's Interim and First accreditation, but not likely achievable for NCQA's First accreditation with performance measures as there may be no underlying enrollment to support reporting of HEDIS and CAHPS information.~~

~~Another interpretation of the ACA is that states can establish a scheme in which issuers that are not currently accredited can become accredited within a certain time frame, as HHS had indicated that they will do for the federally facilitated Exchange. In establishing this "grace period" states should bear in mind that the accreditation organizations have indicated that 18 months is the average length of time necessary to become accredited. As noted above, this 18 month period varies by plan readiness. NCQA's full review process takes 3 months, but will be less for Interim Accreditation.~~

As of the date of this paper, several states have already established Exchanges, and have had varying experience in establishing time frames for accreditation. Arizona's Exchange allows issuers to have one year from date of application to sell a product in their Exchange to demonstrate accredited status. Arizona's decision was based on informal work with health plans and consumer advocates and was informed by the fact that most non-accredited issuers were already well on their way towards accreditation.

States will also need to determine the manner in which they establish the time frame, including whether it will require a rule or statute. Arizona simply published its decision. Exchanges in other states might find it necessary to establish the time frame in a more formal manner, such as via bulletin, regulation or statute.

States may also need to consider what will occur if an issuer attempts but fails to achieve accreditation by the expiration of the required time frame. Historically, the formal accreditation process was sufficiently resource intensive that issuers would not pursue accreditation if they were not reasonably confident they would succeed. Issuers may also have feared negative publicity resulting from an accreditation denial. URAC has corrective-action requirements for organizations undergoing accreditation review and that NCQA provides feedback to plans on areas with poor performance and allows plans second review if plans are denied accreditation initially. There are some built in measures to manage situations of denied

accreditation, however states should also consider ramifications if decertification is required. For example, if denied, an issuer can have an additional 6 months to correct its performance and then undergo an expedited review by the accreditor.

A related topic that states should consider are other consequences resulting from decertifying a QHP due to failure to achieve accreditation within the specified time period. For example, while an individual may still have guaranteed renewability rights under HIPAA, if their plan is decertified for failure to achieve accreditation, their plan would no longer be available on the Exchange. Similarly, issues surrounding state subsidies should also be considered. If an enrolled individual's chosen plan is de-certified, subsidies are not available outside the Exchange even though HIPAA gives those individuals a right to guaranteed renewability. States may also want to consider implications for small employers purchasing coverage in the SHOP Exchanges.

States may wish to inquire with accrediting entities about timing based on the volume of issuers in their states that have approached them about accreditation since enactment of the ACA. In those states that currently have many of the plans accredited for other commercial, Medicaid or Medicare products there will not be a large influx of plans, and the accrediting entities may perform a shorter and limited review of those plans that are currently accredited. State regulators may also want to keep in mind that additional accreditation entities may seek to play a larger role in accreditation of issuers to meet demand and preserve competition.

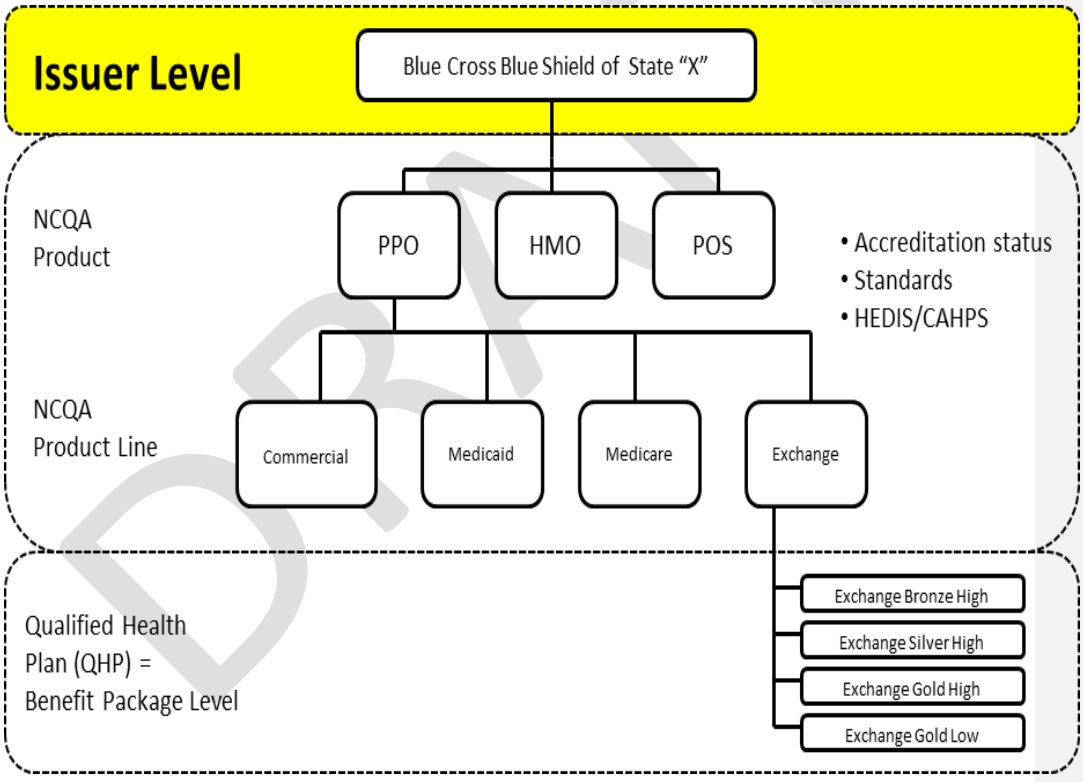
e. How Well Does Accreditation Line Up with Policy Forms?

There is considerable confusion in the ACA, related to federal regulations and various external information sources in how the terms "plan" and "product" are defined and used. For state insurance regulators, there may not be much if any distinction for regulatory purposes between these terms. Existing federal laws such as HIPAA, MHPEA and ERISA, and now the ACA, attach different meanings to these terms. To complicate matters, URAC and NCQA accreditation status is awarded to entities that may or may not be recognizable to state insurance regulators. It is clear from materials available from URAC and NCQA that accreditation could be issued to in a variety of ways: to an insurance company, a holding company, a single product or product line within a company but NOT the whole company, one geographic part of a company's total geographic territory, etc. Accrediting entities have expressed interest in working with the NAIC to match levels of accreditation to NAIC codes.

Currently, each URAC accreditation attaches directly to a state licensed issuer and applies to all lines of the issuer's business in a given state (e.g., QHP, commercial, Medicaid). So, for example, in the case of a national insurer that operates QHP issuers in multiple states, a URAC accreditation certificate number is not issued to the parent company. Instead, each state-licensed QHP issuer operated by the parent company receives a separate on-site review by URAC and receives its own unique URAC accreditation certificate.

In conducting the on-site review, URAC verifies that the name of the legal entity seeking accreditation is directly matched to a state insurance license. URAC also conducts a review to ensure that each product offered by the issuer (e.g. HMO, PPO, POS) and every product line (QHP, commercial, Medicaid) meets URAC accreditation standards as well as any state specific requirements. When URAC issues an accreditation certificate, it is specific to a state-licensed issuer and the certificate lists each product and product line that is included in the accreditation. URAC has indicated that they could also list on the certificate the state license identifier and NAIC code for the accredited entity. However, states should verify that the accreditation achieved is the appropriate level for qualification for the Exchange.

The following chart, supplied by NCQA, demonstrates what level NCQA accreditation and quality data collection occurs:



The challenge with this approach, for state insurance regulators, is that it does not resemble or correlate to state licensure, market regulation, or solvency laws, which are the general parameters by which state insurance regulators recognize a "plan". For example, in many

states, licensure as an insurance company precludes the sale of HMO products, and vice-versa. Licensure as an HMO precludes the sale of insurance products. You would not have one company that delivered both PPO and HMO products under the same license. Therefore, the accreditation that NCQA's chart indicates actually would apply to at least two separately licensed entities in the eyes of the state insurance regulators. Yet only one accreditation has been awarded from NCQA.

In many cases, it may not be easy for states to identify which insurance policies or products or plans line up with an accreditation and which ones do not. This is an area where SERFF might be useful. SERFF staff have worked closely with state and federal officials to adapt SERFF to meet new needs under the ACA. When making a policy form filing in the SERFF system for state approval purposes, the SERFF system could be adapted to reflect whether or not the company proposes to use the form(s) in that filing in or out of the Exchange, or both, as well as the evidence of accreditation status necessary if the form is for purposes of supporting plans sold through the Exchange. If necessary, states could establish state-specific submission requirements in SERFF, although doing so might create a lack of uniformity across states.

In their June 1, 2012, proposed rule, HHS proposed that accreditation should be done for each product type offered by a QHP issuer in each Exchange, based on data submitted by the issuer that is representative of the population of each qualified health plan in that Exchange product type.[15]

Consumer groups note that QHP accreditation, rating and reporting should tied as closely as possible to the particular plan in which an individual is enrolling, in order to permit consumers to make plan comparisons based on quality and the most transparency. They oppose accreditation at the holding company level.

Both NCQA and URAC have demonstrated unhesitating willingness to work closely with state and federal regulators to assure smooth implementation of the ACA requirements. This cautionary note is simply to advise state insurance regulators to pay close attention to the details of accreditation awards.

~~e~~f. Dental plans

Stand-alone dental plans offered in an Exchange are considered to be a type of QHP. These plans must meet consumer protection standards, such as offering benefits without annual and lifetime limits.[16] However, the federal rule recognizes the unique nature of stand-alone dental plans and permits Exchanges to establish standards that are specific to stand-alone dental plans. The final rule also establishes that stand-alone dental plans must comply with QHP certification standards, except for those certification standards that cannot be met because the stand-alone dental plans covers only pediatric dental benefits. To the extent that accreditation

[15] 45 CFR §156.275(c)(2)(iii).
[16] 45 CFR §155.1065.

standards specific to stand-alone dental plans do not exist, such plans would not have to meet the requirement that QHPs not already accredited must become accredited within the uniform period established by Exchanges.[17]

There are currently no accreditation standards specifically for dental plans. It does not appear that such standards are likely to be developed by the health plan accrediting entities specifically for dental plans. Dental plans believe, and urge, that accreditation standards should not be applicable to dental.

States should be aware that URAC does currently accredit ~~several~~ a few dental plans to varying degrees. URAC's accreditation is offered in modular format, for specified activities, such as utilization management for example. These can be applied to a broad range of entities that perform utilization management, including dentistry. Therefore, some of URAC's accreditation awardees are dental plans that have earned accreditation in a module applicable to the business of operating a dental plan (such as utilization management). States may wish to consider if a particular URAC module is reasonable to expect a certified dental plan to obtain. In considering this option however, states should keep in mind that extremely few dental plans have any accreditation, and that for pediatric-only dental plans, the costs and administrative burden of accreditation may outweigh any benefit. -

~~f~~g. Co-ops

Neither the ACA nor federal regulations regarding co-ops provide an exception for co-ops in terms of obtaining accreditation for their QHPs, or for complying with quality reporting requirements. Because co-ops are intended to have no connection to any existing insurance plans, co-ops will therefore also have no experience, no maturity with data collection and reporting, and no statistically valid pool to sample, or from which to pull data. The federal regulations establish a phase-in time frame for co-ops to earn accreditation which mirrors the phase-in time frame extended to all unaccredited plans. However, given co-ops' lack of claims experience, the application of the accreditation and quality requirements to co-ops will be particularly challenging. URAC's modular options for accreditation, as discussed above in relation to dental plans, may be a suitable and appropriate route for co-ops.

4. Quality Elements in the Exchanges

The federal regulation requires Exchanges to evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting.[18]

a. Requirement to Evaluate Quality Improvement Strategies

[17] Exchanges Final Rule, Provisions of the Proposed Regulation and Analysis and Response to Public Comments, p. 18412 describing §155.1065 and §155.1045.
[18] ACA, Section 1311(c)(1), 1311(c)(3), and 1311(c)(4).

The ACA requires QHP issuers to implement a quality improvement strategy. This is a requirement separate from the accreditation process. Exchanges are required to evaluate these quality improvement strategies.[19] As of the date of this paper, HHS has not issued additional guidance, although such guidance is anticipated. At present, this paper will assume that Exchanges will collect data from QHP issuers that shows health status and health outcomes.

HHS intends to propose a phased approach to new quality reporting and display requirements for all Exchanges and expects that state-based Exchanges may adopt a similar approach prior to final regulatory standards. It is anticipated, for example, that HHS will propose that reporting requirements related to all QHP issuers will start in 2016. We understand HHS intends to support the calculation of the QHP-specific quality rating for all QHP issuers in all Exchanges. The QHP-specific quality rating would be available for display in 2016 open enrollment for the 2017 coverage year. In the interim, a federally facilitated Exchange will display existing CAHPS data that are available for the same QHP product types and adult/child populations.[20] Federally facilitate Exchanges will not display other data drawn from the accreditation data, such as clinical measures results.

HHS intends to engage in rulemaking for quality reporting and disclosure requirements for all Exchanges. HHS also intends to solicit stakeholder input on the most effective ways to align the quality reporting and display requirements for QHPs in 2016 and beyond with related quality measurement initiatives across HHS (for example, the National Quality Strategy, section 2717 of the ACA, and quality reporting requirements under Medicare and Medicaid).

The statutory language regarding quality improvement strategies refers to "market based incentives". These are defined as "increased reimbursement" or other incentives for specified outcomes or implementation of certain activities. Therefore, it appears that, at a minimum, "quality improvement" means more money for achieving outcomes or implementation activities. The use of the term "reimbursement" appears to assume the incentive is aimed at those who are reimbursed by health plans. In most cases, medical providers are reimbursed by health plans. It appears that the intent of the ACA is that QHP issuers will pay providers more if providers demonstrate achievement of desired outcomes. "Other incentives" can certainly mean almost anything, including but not limited to reduced out-of-pocket costs for health plan members.

Although accreditation programs could be used to demonstrate how plans are meeting quality improvement strategies, it is unclear, pending further federal guidance, whether accreditation will be considered sufficient to meet such quality improvement strategies. Both URAC's and NCQA's health plan accreditation programs include standards related to operation of an

[19] 45 CFR §155.200(d) states, "*Quality activities:* The Exchange must evaluate quality improvement strategies…in accordance with sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Affordable Care Act."
[20] For example, HMO Adult CAHPS results for HMO QHPs, or Child CAHPS results for child-only QHPs.

effective internal quality improvement program which, in part requires analyzing performance based on quality measures, and conducting corrective action and follow-up based on these findings.

Consumer groups suggest that the goal of establishing quality improvement strategies is to help provide incentives for providers to provide, and for consumers to choose, the highest quality, highest value health plans and providers. For providers, these may include incentives to implement patient-centered care initiatives that focus on improving health outcomes, preventing readmissions, improving care coordination, advancing patient safety, reducing medical errors, and reducing disparities in care. For consumers, this would encourage the use of services and programs that improve health and may include the use of patient-centered tools designed to discourage utilization of expensive services that do not add value when good alternatives exist. QHPs may be able to demonstrate quality improvement strategies by making a commitment to higher reimbursement for primary care, increased access to primary care services, and adopting strategies towards achieving a coordinated, patient-centered, value-based delivery system.

States may want to address state-specific health issues in their review of QHPs' quality improvement strategies, and to ensure that the strategies are consistent with the three-part aim identified in the National Quality Strategy: better care, healthy people and communities, and affordable care.[21]

Consumer groups have suggested that HHS establish a standardized set of metrics that the NAIC can adopt to ensure comparability across QHPs and state Exchanges. However, insurers have raised concerns that quality improvement strategies will not be comparable across plans because of population differences and socioeconomic factors and therefore would not be an accurate reflection of the effectiveness of such programs. One potential challenge to quality reporting in the Exchange relates to the expected influx of individuals who have not previously had access to coverage. These individuals will likely have unmet health needs that will affect initial efforts to improve quality. At least initially, measurements of quality improvement are expected to be unreliable as a significant volume of previously uninsured people are introduced into the system. Guidance related to federally facilitated Exchanges provides for a phase-in of quality reporting requirements to account for this initial instability.

In order to assist state Exchanges in evaluating quality improvement strategies, states may also want to consider some potential tools such as SERFF, All-Payer Claims Databases, and MCAS (described earlier in the paper).

1. SERFF

The System for Electronic Rate and Form Filings (SERFF) is an NAIC-owned, internet-based tool used by 49 states, the District of Columbia and Puerto Rico as well as more than 3,400 insurers,

[21] For more information about the National Quality Strategy, view: www.ahrq.gov/workingforquality/ngs/.

for purposes of submitting, receiving, reviewing and approving insurance company product filings (e.g., rate, form, rule, and advertising). The SERFF system has automated the historically manual, paper-intensive filing process. Today, it is estimated that more than 95% of all product filings travel through the SERFF system. NAIC SERFF staff have been actively working with state insurance regulators, insurers, the federal government and other third parties, such as URAC and NCQA, to explore adaptations that would support health plan management functions which states may elect to perform in a health insurance Exchange regardless of the exchange model implemented (state-based, partnership or full federally facilitated exchange). State insurance regulators and the health insurance industry agree they would benefit significantly in terms of administrative consistency and support if the SERFF system could be modified to support QHP issuer accreditation and quality improvement data. SERFF staff has already proven that they are willing and able to modify the SERFF system to support new functions related to the federal health insurance reforms in other areas, notably in support of health insurance rate review functions and data reporting to the federal government.

Current plans are underway to ensure SERFF will serve a role in the new Exchange environment. Details related to the role of SERFF, as the primary plan management tool have been evaluated. Phase 1 of this initiative was approved as part of the NAIC's 2012 budget process and Phase 2, while currently underway, will be formally approved in the upcoming 2013 budget process. Modifications to the SERFF system will be funded by the states through their federal grant funds, either for exchanges or rate review.

2. All-Payer Claims Databases

Some states have implemented an All-Payer Claims Database (APCD) which could potentially be used to evaluate quality improvement strategies and oversee plan quality.[22] APCDs are enjoying some popularity among policymakers because of the potential to gather, control, analyze and manipulate a tremendous amount of public health information.

However, it is important to note that thus far those are claims databases and do not collect quality information on quality initiatives or outcomes. For purposes of this paper, both the medical provider community and the health insurance industry expressed significant concern with the state of development of APCDs and the use of APCDs in the 14 states that have enacted legislation to collect claim or remittance information.

To address some of the complex data challenges, the Accredited Standards Committee X12 and the APCD Council are currently attempting to develop a national standard or standards for reporting from APCDs. Though the X12 standards may clarify some reporting issues, we understand these standards may not address other issues such as inconsistent data definitions among payers, which is one of the major impediments to using APCDs information for comparative quality reporting purposes. The technology is considered to be still under

[22] For more information about APCDs, readers may evaluate information publicly available from www.apcdcouncil.org and www.x12.org.

development and it may be many years before APCDs can be expected to serve a significant role in state health planning.

b. Requirement to Oversee Implementation of Enrollee Satisfaction Surveys

Specific reference is made to Consumer Assessment of Healthcare Providers and Systems (CAHPS) and HHS plans to develop an enrollee satisfaction survey based on CAHPS.[23] CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. The survey is a set of instruments established and maintained by the Agency for Healthcare Research and Quality (AHRQ). However, AHRQ does not administer the survey. It is publicly available and is nationally recognized as a valid and uniform instrument for surveying consumer satisfaction with health care service delivery and financing systems.

NCQA currently uses CAHPS surveys. URAC has routinely accepted CAHPS data as part of meeting is standards and, with the release of the current URAC Health Plan Accreditation Program (Version 7, 2011), URAC now requires CAHPS reporting.

The ACA requires Exchanges to "oversee implementation of enrollee satisfaction surveys".[24] The Exchange must also post enrollee satisfaction survey results on the Exchange website so that the public can compare satisfaction across plans. States can elect to deem an accredited plan to meet any state specific standards for surveying consumer satisfaction.

Several different survey instruments are available including "Health Plan," "Clinician and Group," "Hospital," and others. One survey instrument that does not currently exist is "Exchange." Therefore, where the ACA and associated regulations require state Exchanges to "oversee" surveys of consumer satisfaction, it appears this refers to surveys of consumer satisfaction with the health plans specifically sold as QHPs through the Exchanges. It does not appear that Exchanges must directly administer such surveys, but Exchanges are responsible for overseeing surveys administered by QHPs on their own membership. This is another area, however, where it would be questionable for Exchanges to duplicate the work already being carried out by the accrediting entities. To the extent permitted by future federal guidance, Exchange activity in this area should defer to accreditation standards. If anything, Exchanges may wish to voluntarily undertake their own customer satisfaction surveys, specifically because there is currently no CAHPS instrument specific to "Exchange".

c. Requirement to Support a Website that Provides Standardized Comparative Information on Quality Ratings

It is anticipated that further regulatory guidance will be issued before Exchanges are required to implement a quality rating system. It is anticipated that HHS intends a phased approach to the quality rating provisions in which quality ratings in 2014 would be predicated on generally

[23] For more information, see www.cahps.ahrq.gov.
[24] 45 CFR §155.200(d) and ACA Section 1311(c)(4).

available and collected metrics and measures, and moving to a QHP-specific rating in 2016. Once implemented, it is part of the obligation of Exchanges to oversee implementation of "assessment and ratings of health care quality and outcomes, information disclosures, and data reporting."[25]

Numerous organizations across the country have websites providing comparative information on health plans. Quality reporting information on such comparative websites, in conjunction with cost information, will assist consumers in making decisions based on value. The Massachusetts Health Connector web site, which includes data on accreditation and quality, is one resource that states may wish to look as they design and implement a quality rating system.[26] Another helpful example may be the Getinsured.com website, which also displays accreditation information.[27] A third useful tool is the Consumers CHECKBOOK plan compare tool.[28]

There are additional requirements in the ACA and Exchange regulations on what the Exchange website should support, but for purposes of this paper, the focus is on allowing consumers to compare plans on a quality and price basis, where certain minimum required plan features are expected to be the same across all plans, such as coverage for preventive services and essential health benefits. State exchanges may want to develop their quality initiatives closely in concert with the development of the web portal and other consumer assistance tools, to ensure that the quality measurement efforts will support and contribute to the use of this information by consumers.

When thinking about providing quality information to Exchange enrollees on websites, NCQA has suggested two phases of presenting the quality information on websites. In the early years, there will be limited quality information available because there is no Exchange population to measure. In this first phase of the Exchange, the websites can report how a plan performed on accreditation. URAC urges that, since access to health plan quality information is essential to consumers and that this information would be the most widely available to consumers when provided through the Exchange websites.

c. Quality Best Practices and Related Issues

States have a variety of options to evaluate and adopt best practices in healthcare and health plan quality oversight. There are a number of organizations devoted to improving quality in the health care context. AHRQ, described above, is the lead federal agency responsible for improving the quality, safety, efficiency and effectiveness of healthcare for Americans. Other federal agencies, as well as some state-based organizations and private and public-private partnerships are also involved in quality-related activity.

[25] 45 CFR §155.200(d).
[26] www.mahealthconnector.org/portal/site/connector/
[27] www.getinsured.com
[28] www.checkbook.org/plancompare/

While this paper is focused on accreditation and quality requirements relating to Exchanges, state regulators have other responsibilities related to insurer quality and reporting under the ACA. Implementation of these related areas should be carefully coordinated. Section 2717 of the ACA requires HHS to develop reporting requirements for plans regarding coverage provisions and provider reimbursement structures intended to improve outcomes, reduce hospitalizations, and improve patient safety, among other goals. Sections 2715(a), 1311(e) and 2718 also require insurers to report data to the Exchange, the state insurance department, and HHS. State insurance departments may also want to carefully monitory quality improvement activities for which carriers claim expenses in the numerator of their medical loss ratio calculations under Section 2718.

Accrediting entities offer information and guidance on best practices. According to NCQA, 41 states currently use its accreditation information in their oversight of health plans. Of those, 37 apply it to commercial plans and 29 apply those requirements for Medicaid contracted plans. Commercial state regulators vary in their use of accreditation but the most commonly recognized standards include the areas of utilization management and credentialing.

There is an NAIC health plan quality model (#71 – dated 1996). One state (Nebraska) has adopted it in total, and 26 states are identified as having adopted it in part, although in some cases the requirements only apply to HMOs.

Many states have a long history of using elements (e.g. utilization management and credentialing) of or whole quality programs (health plan accreditation) from accreditors. State Medicaid programs have historically been more active in review of health plan quality than state insurance regulators, through state Medicaid managed care programs. States can tap their Medicaid managed care programs for guidance and support in developing quality oversight programs applicable to commercial health insurance.

In Tennessee, the TennCare program participated in a webinar with Academy Health and NCQA regarding quality. While states should consider the differences between Medicaid and commercial insurance markets, the TennCare officials offered the following items as important "lessons learned" in their 15+ year history of overseeing a state-wide effort at improving quality for Medicaid beneficiaries:

1. Access to reliable encounter data as quickly as possible is extremely important. Hard data is needed to dispel misinformation.
2. Quality requirements should be spelled out for health plans – e.g., accreditation requirements and timelines and performance measure reporting requirements. Accreditation takes time so clear milestones should be established to assess progress toward the goal. Consider pay-for-performance arrangement to reward plans for accreditation level received.
3. Independent, external review (EQRO, an accrediting entity like NCQA or URAC) goes a long way to quelling stakeholder concerns.

4. Required reporting of standardized, evidenced-based performance measures for MCOs allows tracking trends over time and for comparison to national norms (e.g. HEDIS).
5. Consider developing a state level survey that will allow you to track issues of interest to the state over time. This would be in addition to MCO level surveys like CAHPS.
6. Pay for Performance incentives tied to specific performance measures can be used effectively to target attention to your highest priorities.
7. Network monitoring should include three components:
    - Establishment of network standards for various provider types (e.g., geographic, appointment time)
    - Tracking compliance with standards based on network information self-reported by MCOs.
    - An audit process to validate MCO self-reported information
8. Tracking and analysis of enrollee appeals can be an important quality monitoring tool.

The Medicaid Health Plans of America (MHPA) offers guidelines for Medicaid managed care programs in specific clinical issues to enhance the overall health of Medicaid populations. Their web site also offers access to a wide range of clinical, administrative and policy publications, many at no cost. Other public and private organizations, from consulting firms to research organizations to advocacy groups, offer a wide range of papers, discussions, research articles, webinars and other resources for little or no cost, exploring a wide range of issues in health plan quality improvement strategies. Common themes that appear to recur in much of this literature include:

- The importance of data collection and state-of-the-art data systems that can support powerful analysis
- An emphasis on clinical quality measures, with somewhat less information and guidance on administrative quality improvement approaches
- An emphasis on behavioral incentives for medical providers and patients, beyond clinical excellence – in other words, the best clinical care can be ineffective if not accompanied by incentives that remove administrative barriers to delivery. Proper and timely communication between providers and patients is an important goal.
- Achieving an appropriate balance between data reporting and collection and minimizing unnecessary and unhelpful administrative burdens. The public wants standardized, comparable health plan information, often in highly specialized areas such as treating children with autism or longevity following cancer treatment. The public also wants privacy protection and affordable care. These two things actually work against each other and will require constant monitoring and perpetual re-balancing.

5. Distinctions Based on Exchange Status

Exchanges may be entirely state-operated, or states may develop partnerships with HHS to share certain responsibilities. Even if the Exchange is entirely federally facilitated, states should be aware of the quality and accreditation issues. States with existing state law requirements for health plan accreditation and quality may be well positioned to manage Exchange operations related to these requirements.

Regardless of the Exchange status, state insurance regulators will play a modified role in health plan oversight. Where the Exchange is operated by the state, the role of state insurance regulators will not change as much as might be the case with a federally facilitated Exchange, but there will still be a change. For example, in areas of market conduct and consumer support, state insurance regulations may be superseded by new Exchange requirements. Insurance regulatory interactions with Medicaid managed care plans and state Medicaid agencies will be dramatically different. Even in the area of health plan solvency, insurance regulators will be dealing with the financial impacts of new plan growth, new plans in the market place (particularly co-op plans with no prior insurance experience), and large numbers of new entrants into the insurance market. Although the ACA includes no new financial solvency requirements, state insurance regulators will be wise to keep close track of the financial stability of health plans operating in a fundamentally different market than has existed prior to the ACA.

In states where there is a partnership Exchange, state insurance regulators will develop new relationships with their federal partners for exchange of information and resources. In addition to supplying information to federal partners, state insurance regulators will have a new opportunity to receive information from federal partners regarding the behavior of health plans in the new market place. The history of state insurance regulators working together will serve states well in designing relationships with federal partners that are both responsive to unique needs from state to state, and also uniform where necessary and appropriate.

Finally, state insurance regulatory relationships with regulated health plans, and with consumers, will continue to be critical. Particularly with regard to the role of accreditation, the ability of state insurance regulators to evaluate health plan quality, and the impact of new reporting requirements, states' ongoing communication with industry and consumers will remain a significant component and will continue to demand significant resources from state insurance regulatory agencies. This will be true regardless of which type of Exchange is established in a state.

PPACA Quality and Accreditation Requirements related to Exchanges

Critical "musts", "shalls", and "requireds" are highlighted in the excerpts below from ACA and from subsequent federal regulations, related to Exchanges and QHP accreditation and quality. The highlighted excerpts formed the basis for the organization of this paper.

SEC. 1311

…

(c) Responsibilities of the Secretary-

(1) IN GENERAL- The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum—

…

(D)(i) be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or

(ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;

(E) implement a quality improvement strategy described in subsection (g)(1);

…

(g) Rewarding Quality Through Market-Based Incentives-

(1) STRATEGY DESCRIBED- A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for--

(A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;

(D) the implementation of wellness and health promotion activities; and

(E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.

Provisions from federal regulation 45 CFR Sec. 155.1045 and 156.275 for Accreditation, and Sec. 155.200, 155.205, and 156.200 for Quality

§ 155.1045 Accreditation timeline.
The Exchange must establish a uniform period following certification of a QHP within which a QHP issuer that is not already accredited must become accredited as required by § 156.275 of this subtitle, except for multi-State plans. The U.S. Office of Personnel Management will establish the accreditation period for multi-State plans.

§ 156.275 Accreditation of QHP issuers.
(a) *General requirement.* A QHP issuer must:
(1) Be accredited on the basis of local performance of its QHPs in the following categories by an accrediting entity recognized by HHS:
(i) Clinical quality measures, such as the Healthcare Effectiveness Data and Information Set;
(ii) Patient experience ratings on a standardized CAHPS survey;
(iii) Consumer access;
(iv) Utilization management;
(v) Quality assurance;
(vi) Provider credentialing;
(vii) Complaints and appeals;
(viii) Network adequacy and access; and
(ix) Patient information programs, and
(2) Authorize the accrediting entity that accredits the QHP issuer to release to the Exchange and HHS a copy of its most recent accreditation survey, together with any survey-related information that HHS may require, such as corrective action plans and summaries of findings.
(b) *Timeframe for accreditation.* A QHP issuer must be accredited within the timeframe established by the Exchange in accordance with § 155.1045 of this subchapter. The QHP issuer must maintain accreditation so long as the QHP issuer offers QHPs.

Subpart C—General Functions of an Exchange

§ 155.200 Functions of an Exchange.
(a) *General requirements.* The Exchange must perform the minimum functions described in this subpart and in subparts D, E, H, and K of this part.
(b) *Certificates of exemption.* The Exchange must issue certificates of exemption consistent with sections 1311(d)(4)(H) and 1411 of the Affordable Care Act.
(c) *Oversight and financial integrity.* The Exchange must perform required functions related to oversight and financial integrity requirements in accordance with section 1313 of the Affordable Care Act.
(d) *Quality activities.* The Exchange must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting in accordance with sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Affordable Care Act.
(e) *Clarification.* In carrying out its responsibilities under this subpart, an Exchange is not operating on behalf of a QHP.

§ 155.205 Consumer assistance tools and programs of an Exchange.
(a) *Call center.* The Exchange must provide for operation of a toll-free call center that addresses the needs of consumers requesting assistance and meets the requirements outlined in paragraphs (c)(1), (c)(2)(i), and (c)(3) of this section.
(b) *Internet Web site.* The Exchange must maintain an up-to-date Internet Web site that meets the requirements outlined in paragraph (c) of this section and:
(1) Provides standardized comparative information on each available QHP, including at a minimum:
(i) Premium and cost-sharing information;
(ii) The summary of benefits and coverage established under section 2715 of the PHS Act;
(iii) Identification of whether the QHP is a bronze, silver, gold, or platinum level plan as defined by section 1302(d) of the Affordable Care Act, or a catastrophic plan as defined by section 1302(e) of the Affordable Care Act;
(iv) The results of the enrollee satisfaction survey, as described in section 1311(c)(4) of the Affordable Care Act;
(v) Quality ratings assigned in accordance with section 1311(c)(3) of the Affordable Care Act;
(vi) Medical loss ratio information as reported to HHS in accordance with 45 CFR part 158;
(vii) Transparency of coverage measures reported to the Exchange during certification in accordance with § 155.1040; and
(viii) The provider directory made available to the Exchange in accordance with § 156.230.
(2) Publishes the following financial information:
(i) The average costs of licensing required by the Exchange;
(ii) Any regulatory fees required by the Exchange;
(iii) Any payments required by the Exchange in addition to fees under paragraphs (b)(2)(i) and (ii) of this section;
(iv) Administrative costs of such Exchange; and
(v) Monies lost to waste, fraud, and abuse.
(3) Provides applicants with information about Navigators as described in § 155.210 and other consumer assistance services, including the toll-free telephone number of the Exchange call center required in paragraph (a) of this section.
(4) Allows for an eligibility determination to be made in accordance with subpart D of this part.
(5) Allows a qualified individual to select a QHP in accordance with subpart E of this part.
(6) Makes available by electronic means a calculator to facilitate the comparison of available QHPs after the application of any advance payments of the premium tax credit and any cost sharing reductions.
(c) *Accessibility.* Information must be provided to applicants and enrollees in plain language and in a manner that is accessible and timely to—
(1) Individuals living with disabilities including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.
(2) Individuals who are limited English proficient through the provision of language services at no cost to the individual, including
(i) Oral interpretation;
(ii) Written translations; and

(iii) Taglines in non-English languages indicating the availability of language services.
(3) Inform individuals of the availability of the services described in paragraphs (c)(1) and (2) of this section and how to access such services.
(d) *Consumer assistance.* The Exchange must have a consumer assistance function that meets the standards in paragraph (c) of this section, including the Navigator program described in § 155.210, and must refer consumers to consumer assistance programs in the State when available and appropriate.
(e) *Outreach and education.* The Exchange must conduct outreach and education activities that meet the standards in paragraph (c) of this section to educate consumers about the Exchange and insurance affordability programs to encourage participation.

§ 156.200 QHP issuer participation standards.
(a) *General requirement.* In order to participate in an Exchange, a health insurance issuer must have in effect a certification issued or recognized by the Exchange to demonstrate that each health plan it offers in the Exchange is a QHP.
(b) *QHP issuer requirement.* A QHP issuer must—
(1) Comply with the requirements of this subpart with respect to each of its QHPs on an ongoing basis;
(2) Comply with Exchange processes, procedures, and requirements set forth in accordance with subpart K of part 155 and, in the small group market, § 155.705 of this subchapter;
(3) Ensure that each QHP complies with benefit design standards, as defined in § 156.20;
(4) Be licensed and in good standing to offer health insurance coverage in each State in which the issuer offers health insurance coverage;
(5) Implement and report on a quality improvement strategy or strategies consistent with the standards of section 1311(g) of the Affordable Care Act, disclose and report information on health care quality and outcomes described in sections 1311(c)(1)(H) and (I) of the Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Affordable Care Act;
(6) Pay any applicable user fees assessed under § 156.50; and
(7) Comply with the standards related to the risk adjustment program under 45 CFR part 153.
(c) *Offering requirements.* A QHP issuer must offer through the Exchange:
(1) At least one QHP in the silver coverage level and at least one QHP in the gold coverage level as described in section 1302(d)(1) of the Affordable Care Act; and,
(2) A child-only plan at the same level of coverage, as described in section 1302(d)(1) of the Affordable Care Act, as any QHP offered through the Exchange to individuals who, as of the beginning of the plan year, have not attained the age of 21.
(d) *State requirements.* A QHP issuer certified by an Exchange must adhere to the requirements of this subpart and any provisions imposed by the Exchange, or a State in connection with its Exchange, that are conditions of participation or certification with respect to each of its QHPs.
(e) *Non-discrimination.* A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.